

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to filing and withdrawal of appeals

The Human Services Department hereby amends Chapter 7, “Appeals and Hearings,” Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 217.6.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 217.6.

Purpose and Summary

Federal regulations allow providers and authorized representatives to file an appeal on behalf of a Medicaid member for managed care appeals when the member has given the member’s express written consent. These amendments implement the use of Form 470-5526, Authorized Representative for Managed Care Appeals, to obtain the member’s consent.

These amendments also allow child abuse and dependent adult abuse appeals to be withdrawn on the record before an administrative law judge or in writing and signed by the appellant or the appellant’s legal counsel. Previously, withdrawal requests could only be made in writing. This change provides better access to due process for the Department’s clients.

Federal regulations allow assistance to continue for managed care organization health care services when certain criteria are met. Currently, rule 441—7.9(17A) indicates that assistance only continues if it is for the original period covered by the original authorization. The first use of the term “original” in the rule is a duplication, and it is being removed for clarification purposes.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on May 9, 2018, as **ARC 3783C**.

The Department received comments from one respondent during the public comment period. A summary of the comments and the Department’s response are as follows:

Comments: The respondent argued that the proposed change regarding use of Form 470-5526 to obtain the written consent of the Medicaid member for an appeal appears to add barriers to due process and rights to an appeal. The respondent stated that if the form is not returned, then no state fair hearing is granted. The respondent argued that the requirement to use a specific form or no hearing is granted is overly restrictive and requested that the language be changed from “shall” to “may.” The respondent stated that by making this minor change, the concern of adding barriers to a Medicaid member’s due process rights would be alleviated.

The respondent also suggested adding language to the proposed rule stating that the Department will notify the provider or authorized representative of any defect related to the absence of the form, provide Form 470-5526 to the provider or authorized representative and provide an opportunity to cure before denying a state fair hearing. The respondent did not have an issue with the use of the form, only with the requirement that Form 470-5526 shall be used, and that if the form is not used, the member’s rights to a state fair hearing will be denied.

The respondent also argued that not all Medicaid providers will have access to Form 470-5526 or be aware of the requirement of its use, and that there is no information in the proposed rule regarding how the Department will communicate the required use of Form 470-5526 to Medicaid members or

providers and legal representatives. The respondent expressed concern that there will be a sharp decline in Medicaid members proceeding to state fair hearings because of this requirement.

Department response: Federal regulations at 42 CFR 438.402(c)(1)(ii) allow a provider or authorized representative to file an appeal on a member's behalf "with written consent of the enrollee." There is no requirement in the regulations of how that consent is presented other than to be "in writing," and this gives each state the flexibility to determine how to obtain consent.

Currently, there is no standard protocol for obtaining member consent. It quickly became evident that providers were not appropriately obtaining the member's consent at the time of the appeal.

Providers and authorized representatives have struggled with obtaining member consent. The managed care organizations developed their own form to obtain consent, but the provider or authorized representative often would complete the form and not obtain the member's consent. Providers or authorized representatives have submitted standard releases, consents to treatment, or authorization to release medical records believing this would document the member's consent. The Department has also been contacted by providers and authorized representatives requesting a document that can be used to obtain member consent.

For these reasons the Department created Form 470-5526. The managed care organizations and the Department will utilize this form to obtain member consent in a consistent manner. Federal regulations have always required written consent from the member. The proposed regulations require the use of the form, which will be available on the Department website. Also, providers and the managed care organizations will be notified of the requirement through an informational provider letter.

Because the managed care organization is required to obtain the member's written consent on Form 470-5526 for the first-level appeal process with the managed care organization, the Department intends to obtain a copy of that consent form from the managed care organization when a state fair hearing request is filed. The respondent was concerned that the use of the form would decrease the number of appeals that were eligible for a state fair hearing. The Department disagrees with this concern.

On multiple occasions, the managed care organizations and the Department have had to delay due process rights to members because the member's consent was not adequately obtained. By adding the requirement that consent be obtained on Form 470-5526, the Department is ensuring the member is truly authorizing the provider or authorized representative to file an appeal on the member's behalf.

If there is an instance where member consent was not obtained by the managed care organization during the first-level appeal process and the provider or authorized representative was not previously given an opportunity to provide member consent, the Department will give the provider or authorized representative this opportunity before a state fair hearing request is denied. The Appeals Section already follows this process and will continue to do so in the future. As this is an internal process, it does not need to be identified in the rules. The Department will not amend the rule making as requested.

No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on June 13, 2018.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa. These rules will streamline existing processes and provide better access to due process for the Department's clients.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

These amendments do not include waiver provisions because they confer benefits on those affected and are generally required by federal law that does not allow for waivers. Individuals may request a waiver under the Department's general rule on exceptions at rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on August 8, 2018.

The following rule-making actions are adopted:

ITEM 1. Amend paragraph **7.2(5)“b”** as follows:

b. If a provider or authorized representative is acting on behalf of a member by filing this type of appeal, the member's written consent to appeal must be submitted on Form 470-5526, Authorized Representative for Managed Care Appeals, with the appeal request. If the appeal is filed verbally, the managed care organization or agency is responsible for obtaining the member's written consent for the provider or authorized representative.

ITEM 2. Amend paragraph **7.5(2)“a”** as follows:

a. One of the following issues is appealed:

(1) to (17) No change.

(18) ~~An MCO~~ A provider or an authorized representative, for a managed care appeal, fails to submit a document Form 470-5526, Authorized Representative for Managed Care Appeals, providing the member's approval of the request for appeal.

(19) to (22) No change.

ITEM 3. Amend subrule 7.6(2) as follows:

7.6(2) Authorized representation or responsible party. Persons may be represented for purposes of this chapter by an authorized representative or an individual, ~~or~~ organization, or provider recognized by the department as acting responsibly for an applicant or beneficiary pursuant to policy governing a particular program (hereinafter referred to as a “responsible party”), unless otherwise specified by statute or federal regulations.

a. The designation of an authorized representative must be in writing and include the signature of the person designating the authorized representative. Medicaid members may appoint an authorized representative or provider to act on their behalf during the appeals process regarding an adverse benefit determination made by a managed care organization by signing Form 470-5526, Authorized Representative for Managed Care Appeals. Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person.

b. No change.

c. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible party must ~~sign an agreement~~ affirm that such provider, staff member or volunteer will adhere to the regulations in Part 431, Subpart F, of 42 CFR Chapter IV and in 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflict of interest and confidentiality of information.

d. to f. No change.

g. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority may be submitted ~~online via the department's Web site~~, by mail, by electronic mail, by facsimile transmission or in person.

~~h. For purposes of this rule, the department shall accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission.~~

~~h.~~ h. Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority previously submitted to the department that comply with the requirements of this rule will continue to apply for purposes of appeals, consistent with their terms.

ITEM 4. Amend paragraph **7.8(1)“e”** as follows:

e. A Medicaid provider or an authorized representative requesting a hearing on behalf of the member regarding an adverse benefit determination made by a managed care organization must have the prior express written consent of the member or the member’s lawfully appointed guardian, ~~except when appealing a medical assistance eligibility determination on Form 470-5526, Authorized Representative for Managed Care Appeals.~~ Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person. No hearing will be granted unless the provider submits a document providing the member’s consent to the request for a hearing.

ITEM 5. Amend subrule 7.8(8) as follows:

7.8(8) *Withdrawal.* When the appellant desires to voluntarily withdraw an appeal, the worker, the presiding officer, or the appeals section shall accept a request from the appellant to withdraw the appeal by telephone, in writing or in person. A written request may be submitted in person, by mail or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The appellant may use Form 470-0492 or 470-0492(S), Request for Withdrawal of Appeal, for this purpose. For child abuse and dependent adult abuse appeals, the request to withdraw an appeal must be made on the record before an administrative law judge or in writing and signed by the appellant or the appellant’s legal counsel.

ITEM 6. Amend subparagraph **7.9(5)“a”(4)** as follows:

(4) The ~~original~~ period covered by the original authorization has not expired; and

ITEM 7. Amend paragraph **7.9(6)“d”** as follows:

d. The ~~original~~ period covered by the original authorization has expired; or

[Filed 6/13/18, effective 8/8/18]

[Published 7/4/18]

EDITOR’S NOTE: For replacement pages for IAC, see IAC Supplement 7/4/18.